Family Care Encounter Reporting 2.6 --- Data Dictionary View (HEADER)

This document describes the various data elements contained in the encounter record you will extract and send to the State. The description includes things like data element name, length and data type. In addition, there is a brief definition of the data element as well as some of the validation rules Encounter Reporting will use to verify the data you send us. It's primarily intended as a technical document to assist the MCO IT personnel in creating an extract from your claims history data.

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	ID#	Error Cat.
Begin Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	H003	H
Data Element Description:	The beginning process date used to extract encounter records for the submission.					
Validation Rules:	Valid date format, valid month and valid day for that month. Must be equal to the first day of the posting month. Must be less than or equal to the current date.					
End Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	H004	H
Data Element Description:	The ending process date used to extract encounter records for the submission.					
Validation Rules:	Valid date format, valid month and valid day for that month. Must be equal to the last day of the posting month. Must be less the same year and month of the begin posting date.					
FC: Submission Type	10 Max	A	Y	TEST	H006	H
Data Element Description:	The submission type must be Production.					
Validation Rules:	Must be Production. This value is not case sensitive.					
Number of Records Transmitted	8 Max	N	Y	None	H005	H
Data Element Description:	The number of detail records that are contained within the submission.					
Validation Rules:	Number of Records Transmitted must be equal to the number of detail records in a submission.					

Family Care Encounter Reporting 2.6 --- Data Dictionary View (HEADER)

This document describes the various data elements contained in the encounter record you will extract and send to the State. The description includes things like data element name, length and data type. In addition, there is a brief definition of the data element as well as some of the validation rules Encounter Reporting will use to verify the data you send us. It's primarily intended as a technical document to assist the MCO IT personnel in creating an extract from your claims history data.

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	ID#	Error Cat.
Submission Date	10 Fixed	D (CCYY-MM-DD)	Y	None	H002	H
Data Element Description:	The date the submission was generated at the submitting organization.					
Validation Rules:	Valid date format, valid month and valid day for that month. Must be greater than or equal to the header posting end dates. Must be less than or equal to the current date.					
Submitter Organization ID	8 Fixed	N (00000000)	Y	None	H001	H
Data Element Description:	Eight digit certified Medicaid provider number assigned to the submitting organization.					
Validation Rules:	Must exist in the Submitter Organization ID lookup table.					

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Adjustment Type	1 Fixed	A (0)	S	None	NA	D009	A
Data Element Description:	The type of adjustment. Only applicable for transactions that are adjusting a former Encounter Transaction. These may be assigned by the MCO for credit/debit Encounter Transactions. R = A transaction that is the credit to reverse the adjusted transaction. N = A transaction that is the debit to replace the adjusted transaction.						
Validation Rules:	Required if Record Type is O or C.						
Adjustment Type Detail	2 Fixed	A (00)	N	None	NA	D010	A
Data Element Description:	Specifies the type of adjustment. FC = An adjustment that fully reverses the adjusted transaction. PC = An adjustment that partially reverses the adjusted transaction. NC = An adjustment that has no financial affect but changes demographic or other statistical data.						
Validation Rules:	Must be FC, NC or PC.						
Allowed Amount	18 Max.	N (999999999999999.99)	S	None	NA	D061	S
Data Element Description:	The maximum amount determined by the payer as being allowable under the provisions of the contract prior to the determination of actual payment. The lesser of the Medicaid Rate, MCO Contracted Rate or the amount Billed/Charged by the Provider. Example, the dollar amount of 35.5 can be sent as 35.5 or 35.50. *Field size expanded to 18 (15+decimal+2decimals) to comply with HIPAA.*						
Validation Rules:	Must be NULL for Member share transactions.						
Billing Provider First Name	25 Max.	ANPlus	N	None	Billing Provider First Name (AN, L=25)	D022	P
Data Element Description:	First name of the billing provider.						
Validation Rules:	None, except, if the Billing Provider is an individual, use the Billing Provider First Name.						
Billing Provider ID	80 Max.	ANPlus	S	None	Billing Provider Identifier (AN, L=80)	D020	P
Data Element Description:	The Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.						
Validation Rules:	Required when MA Billing Provider ID is not supplied otherwise it is optional. Required when Billing Provider ID-Qualifier is supplied. When Billing Provider ID-Qualifier is XX this field must be alphanumeric and a fixed length of 10.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Billing Provider ID-Qualifier	2 Max.	AN	S	None	ID Code Qualifier (AN, L=2)	D019	P
Data Element Description:	Qualifies what identification is used in the Billing Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.						
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Required when Billing Provider ID is supplied. Must be XX if the SPC code is a medical service and the Rendering Provider ID-Qualifier is not XX.						
Billing Provider Last Name or Organization	35 Max.	ANPlus	Y	None	Billing Provider Last Name or Organization (AN, L=35)	D021	P
Data Element Description:	Last name of the billing provider or the name of the individual group/clinic, or organization.						
Validation Rules:	None						
Billing Provider Middle Name	25 Max.	ANPlus	N	None	Billing Provider Middle Name (AN, L=25)	D023	P
Data Element Description:	Full middle name of the billing provider.						
Validation Rules:	None						
Charges	18 Max.	N (999999999999999.99)	S	None	Line Item Charge Amount (AN, L-18)	D056	S
Data Element Description:	The amount charged by the Provider. (This is the amount billed for this line item only. If multiple details are being billed on one claim do not enter the total claim billed amount). Example, the dollar amount of 35.5 can be sent as 35.5 or 35.50. *Field size expanded to 18 (15+decimal+2decimals) to comply with HIPAA.*						
Validation Rules:	Must be provided for an Encounter transaction. Must be NULL for Member share transactions.						
Claim Adjustment Reason Code	3 Max.	AN	S	None	Claim Adjustment Reason Code (ID, L=3)	D011	S
Data Element Description:	Claim Adjustment Reason Code.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. If the Claim Status field = D or if the amount paid differs from the amount charged a reason code must be provided in the Claim Adjustment Reason Code field. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Claim Adjustment Reason Code 2	3 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=3)	D012	S
Data Element Description:	Claim Adjustment Reason Code 2.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 3	3 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=3)	D013	S
Data Element Description:	Claim Adjustment Reason Code 3.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 4	3 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=3)	D014	S
Data Element Description:	Claim Adjustment Reason Code 4.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 5	3 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=3)	D015	S
Data Element Description:	Claim Adjustment Reason Code 5.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 6	3 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=3)	D016	S
Data Element Description:	Claim Adjustment Reason Code 6.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Claim Status	1 Fixed	A (0)	Y	None	NA	D007	R
Data Element Description:	The current status of the encounter. (P = Paid; D = Denied)						
Validation Rules:	Must be either P or D.						
Claim Type	2 Max	AN	S	None	NA	D097	S
Data Element Description:	Claim form used to fill out the claim.						
Validation Rules:	Must be provided for an encounter transaction and must be NULL for Member share. Must be one of the following values: DE = Dental, IN = Institutional, PH = Pharmacy, and PR = Professional.						
CMO Reason Code	6 Max.	ANPlus	N	None	NA	D017	S
Data Element Description:	County specific reason code. This is a reason code created and maintained by the county.						
Validation Rules:	CMO Reason Code must be an alphanumeric and/or special characters value with a max length of 6.						
Data Source	2 Fixed	AN (00)	Y	01	NA	D003	R
Data Element Description:	Identifies the source of data. Current valid values for Family Care are 01 = Claim System and 03 = Accounts Receivable.						
Validation Rules:	Must exist in the Data Source table and be valid for Family Care.						
Diagnosis Code Additional 2	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D035	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 3	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D036	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Diagnosis Code Additional 4	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D037	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additonal 5	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D038	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 6	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D039	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 7	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D040	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 8	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D041	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Diagnosis Code Additional 9	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D077	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 10	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D035	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 11	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D036	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 12	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D037	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additonal 13	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D038	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 14	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D039	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Diagnosis Code Additional 15	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D040	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 16	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D041	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 17	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D077	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Additional 18	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D077	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
Diagnosis Code Principal	30 Max.	ANDot	N	None	Principal Diagnosis (AN, L=30)	D075	S
Data Element Description:	The full ICD code describing the diagnosis code principal (I.e. the condition established after study to be chiefly responsible for causing the admission or health care episode). The Diagnosis Code Principal found on the Encounter.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Must only provide the Diagnosis Code Principal. Must be NULL for Membershare. Diagnosis Code Principal and additional diagnosis codes must be supplied sequentially without gaps. Service Date From and To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
DRG	3 Max.	N	N	None	DRG (N, L< =3)	D073	S
Data Element Description:	The national DRG code if applicable.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the DRG Code lookup table. Must be Null for MemberShare.						
MA Billing Provider ID	8 Fixed	N (00000000)	S	None	NA	D018	P
Data Element Description:	Medicaid Billing Provider ID.						
Validation Rules:	Required when Billing Provider ID field is not used otherwise it is optional. Must exist in the MA Billing Provider ID lookup table. Service Date From and To must be between the MA Billing Provider ID begin and end dates for the MA Billing Provider ID to be valid for this record.						
MA Rendering Provider ID	8 Fixed	N (00000000)	S	None	NA	D024	P
Data Element Description:	Medicaid Rendering Provider ID.						
Validation Rules:	Must exist in the MA Rendering Provider ID lookup table and be valid for the service date range. Required for Membershare transaction and must equal the Submitter Organization ID. For non-Membershare records it must not equal the Submitter Organization ID. Service Date From and To must be between the MA Rendering Provider ID begin and end dates for the MA Rendering Provider ID to be valid for this record.						
Medicare COB Type	2 Max.	A (99)	S	None	Medicare COB Type (Decimal, L=18)	D104	S
Data Element Description:	When the Medicare COB Type is provided it must conform to the format specified in the Data Dictionary.						
Validation Rules:	The Medicare COB Type must be provided if the Medicare Paid Amount is greater than zero.						
Medicare Paid Amount	18 Max.	N (999999999999999.99)	Y	None	Medicare Paid Amount (Decimal, L=18)	D103	S
Data Element Description:	When the Medicare Paid Amount is provided it must conform to the format specified in the Data Dictionary.						
Validation Rules:	The Medicare Paid Amount must be greater than or equal to zero, and must be equal to zero on member share transactions.						
Member Share	1 Fixed	A (0)	Y	N	NA	D063	A
Data Element Description:	The type of member's share. Supported services are: C = Cost Share, R = Room & Board, V = Voluntary Contribution, S= Spenddown or N = None.						
Validation Rules:	Must be either C, R, V, S or N.						
National Health Plan ID	80 Max.	AN	N	None	Health Plan Identification Number (AN, L=80)	D064	M

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Data Element Description:	The National Health Plan Identifier for this plan.						
Validation Rules:	None						
National Recipient ID	80 Max.	AN	N	None	NA	D065	M
Data Element Description:	The Member's National Subscriber Identifier.						
Validation Rules:	None						
Original ID	80 Max.	ANPlus	Y	None	NA	D006	A
Data Element Description:	The Record ID of the Original record for which all subsequent adjustments were made. This ID will always reference a Record ID.						
Validation Rules:	Must exist on an Original record for that submitting organization. Must exist on an adjustment record.						
Other Payer COB Type Primary	2 Max.	A (99)	S	None	Other Payer COB Type Primary (A, L=2)	D106	S
Data Element Description:	When the Other Payer COB Type Primary is provided it must conform to the format specified in the Data Dictionary.						
Validation Rules:	The Other Payer COB Type Primary must be provided if the Other Payer Paid Amount Primary is greater than zero.						
Other Payer COB Type Secondary	2 Max.	A (99)	S	None	Other Payer COB Type Secondary (A, L=2)	D108	S
Data Element Description:	When the Other Payer COB Type Secondary is provided it must conform to the format specified in the Data Dictionary.						
Validation Rules:	The Other Payer COB Type Secondary must be provided if the Other Payer Paid Amount Secondary is greater than zero.						
Other Payer Paid Amount Primary	18 Max.	N (999999999999999.99)	Y	None	Other Payer Paid Amount Primary (Decimal, L=18)	D105	S
Data Element Description:	When the Other Payer Paid Amount Primary is provided it must conform to the format length specified in the Data Dictionary.						
Validation Rules:	The Other Payer Paid Amount Primary must be greater than or equal to zero, and must be equal to zero on member share transactions.						
Other Payer Paid Amount Secondary	18 Max.	N (999999999999999.99)	Y	None	Other Payer Paid Amount Secondary (Decimal, L=18)	D107	S

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Data Element Description:	When the Other Payer Paid Amount Secondary is provided it must conform to the format specified in the Data Dictionary.						
Validation Rules:	The Other Payer Paid Amount Secondary must be greater than or equal to zero, and must be equal to zero on member share transactions.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Paid Amount	18 Max.	N (999999999999999.99)	Y	None	Payer Paid Amount (AN, L=18)	D058	S
Data Element Description:	The amount paid by the MCO to the provider. (This is the amount paid for this line item only. If multiple details are being paid on one claim do not enter the total claim paid amount). Example, the dollar amount of 35.5 can be sent as 35.5 or 35.50. *Field size expanded to 18 (15+decimal+2decimals) to comply with HIPAA.*						
Validation Rules:	Must be less than or equal to Charges.						
Parent Record ID	80 Max.	ANPlus	S	None	NA	D005	A
Data Element Description:	The Record ID of the record being adjusted. This field is used only when adjusting an existing encounter record. In a credit/debit adjustment both the credit and debit transactions will reference the same transaction Record ID being adjusted.						
Validation Rules:	Must be null on original (O) record types. Required when the record being submitted is an adjustment. Must match the Record ID of an existing record being adjusted. Cannot equal the Record ID of the record being submitted. An adjustment record with the same adjustment type cannot reference the same parent record.						
Place of Service	2 Max.	AN	S	None	Place of Service Code (AN, L=2)	D044	S
Data Element Description:	Place of Service code. (Refer to the place of service appendix in Part K of the WMAP handbook).						
Validation Rules:	Must exist in the Place of Service code lookup table. Must be NULL for Membershare.						
POA Indicator	22 Max.	AN	S	None	POA_Indicator (AN, L=22)	D110	R
Data Element Description:	Diagnosis Present on Admission (POA) Indicator must contain the letters POA followed by a single POA indicator for every secondary diagnosis of patients effective for discharge on or after October 1, 2007. Valid values are: Y = Yes, N = No, U = Unknown, W = Clinically undetermined, 1 = Unrecognized or exempt for POA reporting.						
Validation Rules:	POA_Indicator must contain letters POA, followed by a single POA indicator for every diagnosis code that is reported. Valid values are Y, N, U, W or 1. An "X" or "Z" must follow the last POA indicator associated with the last reported Other Diagnosis. Examples: POAYZ (Principal diagnosis code was reported), POAYNUW1Z (Five diagnosis codes were reported), POAYNUW1YNUW1YNUZ (Thirteen diagnosis codes were reported).						
Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	Adjudication or Payment Date (AN, L=10)	D059	R
Data Element Description:	The date the claim was finalized. For paid claims it is the check date. For denied claims, it is the EOB or notification date. For adjustments it is the posting date.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be within the header posting begin and end dates.						
Procedure Code	48 Max.	AN	S	None	Procedure Code (AN, L=48)	D046	S
Data Element Description:	CPT, HCPCS, local, or national code. Local codes are approved State Local codes and not County or MCO generated local codes. HCPCS is a 5 AN, NDC is 11AN and CPT is 5N						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Procedure Code lookup table. Procedure Code or Revenue code is required. Required if Revenue Code is not present. Service Date From and To must be between the Procedure Code begin and end dates for the Procedure Code to be valid for this record.						
Procedure Code Modifier 1	2 Max.	AN	N	None	Procedure Code Modifier 1 (AN, L=2)	D047	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier lookup table. Modifiers must be filled sequentially without gaps. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Procedure Code Modifier 2	2 Max.	AN	N	None	Procedure Code Modifier 2 (AN, L=2)	D048	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier lookup table. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Procedure Code Modifier 3	2 Max.	AN	N	None	Procedure Code Modifier 3 (AN, L=2)	D049	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier lookup table. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Procedure Code Modifier 4	2 Max.	AN	N	None	Procedure Code Modifier 4 (AN, L=2)	D050	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier 4 lookup table. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Quantity	15 Max.	N (999999999999.99)	S	None	Service Unit Count (AN, L=15)	D052	S
Data Element Description:	The quantitative measure of service rendered according to the service. Example, the quantity of 35 1/2 can be sent as 35.5, 35.50 or 35.500.						
Validation Rules:	Must be present for Encounter Transactions. Must be NULL for Membershare transactions.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Receipt Date	10 Fixed	D (CCYY-MM-DD)	Y	None	NA	D057	S
Data Element Description:	The date the claim was received by the MCO from the provider.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be less than or equal to the detail record posting date.						
Recipient Birth Date	10 Fixed	D (CCYY-MM-DD)	N	None	Birth Date (AN, L=10)	D071	M
Data Element Description:	Birth date for the Recipient.						
Validation Rules:	When supplied, it must be less than or equal to the Service Date From; birth date plus 150 years must be greater than or equal the Service Date To; if the recipient is MA eligible then this birth date must equal the birth date found in the MMIS Eligibility lookup table.						
Recipient Death Date	10 Fixed	D (CCYY-MM-DD)	N	None	Death Date (AN, L=10)	D072	M
Data Element Description:	Death date for the Recipient.						
Validation Rules:	When supplied, it must be less than or equal to the Posting Date; death date plus 1 month must be greater than the or equal Service Date To; if the recipient is MA eligible then this death date must equal the death date found in the MMIS Eligibility lookup table; required if MMIS Eligibility table has a death date for this recipient.						
Recipient First Name	25 Max.	ANPlus	Y	None	Patient First Name (AN, L=25)	D032	M
Data Element Description:	First name of recipient.						
Validation Rules:	None						
Recipient ID	10 Fixed	N (0000000000)	Y	None	Patient's Primary Identification Number (N, L=10)	D030	M
Data Element Description:	Recipient's ten digit Medicaid identification number with no dashs. Fixed length of 10 numbers.						
Validation Rules:	Must exist in the Recipient ID lookup table and be eligible for services from the submitting organization.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Recipient Last Name	35 Max.	ANPlus	Y	None	Patient Last Name (AN, L=35)	D031	M
Data Element Description:	Last name of recipient.						
Validation Rules:	None						
Recipient Middle Name	25 Max.	ANPlus	N	None	Patient Middle Name (AN, L=25)	D033	M
Data Element Description:	Full middle name of recipient.						
Validation Rules:	None						
Record ID	80 Max.	ANPlus	Y	None	NA	D004	R
Data Element Description:	Unique ID assigned by the submitting organization to uniquely identify the record within their organization. This ID is unique to every transaction submitted.						
Validation Rules:	Must not exist for the Organization in the Record ID lookup table detail.						
Record Type	1 Fixed	A (0)	Y	None	NA	D008	R
Data Element Description:	The type of Encounter Transaction. O = An unadjusted transaction. C = Adjusting entries that usually come in pairs. The Credit is to reverse the actual transaction being adjusted and the Debit is to replace the transaction being adjusted.						
Validation Rules:	Must be O or C.						
Rendering Provider First Name	25 Max.	ANPlus	N	None	Rendering Provider First Name (AN, L=25)	D028	P
Data Element Description:	First name of the rendering provider.						
Validation Rules:	None						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Rendering Provider ID	80 Max.	ANPlus	S	None	Rendering Provider Identifier (AN, L=80)	D026	P
Data Element Description:	The Rendering Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.						
Validation Rules:	Required if Rendering Provider Last Name is supplied. Required when Rendering Provider ID-Qualifier is supplied. When the Rendering Provider ID-Qualifier is XX then this field must be alphanumeric and a fixed length of 10.						
Rendering Provider ID-Qualifier	2 Max.	AN	S	None	ID Code Qualifier (AN, L=2)	D025	P
Data Element Description:	Qualifies what identification is used in the Rendering Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.						
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Required if Rendering Provider ID is supplied. Must be XX if the SPC code is a medical service and the Billing Provider ID-Qualifier is not XX.						
Rendering Provider Last Name	35 Max.	ANPlus	S	None	Rendering Provider Last Name (AN, L=35)	D027	P
Data Element Description:	Last name of the rendering provider.						
Validation Rules:	Required if Rendering Provider ID is supplied.						
Rendering Provider Middle Name	25 Max.	ANPlus	N	None	Rendering Provider Middle Name (AN, L=25)	D029	P
Data Element Description:	Full middle name of the rendering provider.						
Validation Rules:	None						
Revenue Code	4 Max.	AN	S	None	NA	D051	S
Data Element Description:	A code which identifies a specific accommodation, ancillary service or billing calculation.						
Validation Rules:	Must exist in the Revenue Code lookup table. Procedure Code or Revenue code is required. Required if Procedure Code is not present. Service Date From and To must be between the Revenue Code begin and end dates for the Revenue Code to be valid for this record.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Service Date From	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date From (AN, L=10) Service Date From and Service Date To are combined into one field on the HIPAA 837 layout.	D042	S
Data Element Description:	The First service date.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be less than or equal to the last day of the posting month.						
Service Date To	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date To (AN, L=10) Service Date To and Service Date From are combined into one field on the HIPAA 837 layout.	D043	S
Data Element Description:	The Last service date.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be greater than or equal to the Service Date From.						
Service Delivery Type	2 Fixed	A (00)	N	None	NA	D076	R
Data Element Description:	The service delivery mechanism. Examples are PC = Program Contract providers, NC = non-program Contract providers, IS = Informal Supports, PH = Public Health, etc.						
Validation Rules:	Must exist in the Service Delivery Type lookup table.						
SPC	6 Max.	AN (999.99)	Y	None	NA	D074	S
Data Element Description:	The specific program (SPC and Subprogram code) which is provided to the client. The subprogram relates to narrow program initiative if appropriate. Refer to applicable manuals for SPC definitions. Decimal is considered character in a non-numeric field.						
Validation Rules:	Must exist in the SPC Code lookup table. Service Date From and To must be between the SPC begin and end dates for the SPC to be valid for this record.						
Submitter Organization ID	8 Fixed	N (00000000)	Y	None	NA	D002	R
Data Element Description:	Eight digit certified Medicaid provider number assigned to the submitting organization.						
Validation Rules:	Must exist in the Submitter Organization ID lookup table.						

Family Care Encounter Reporting 2.6 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837) Name and Characteristics	ID#	Error Cat.
Support Indicator	1 Fixed	A (0)	Y	C	NA	D062	S
Data Element Description:	The type of support this service line item represents. S = Self-directed; C = MCO-directed; N = Non-Services						
Validation Rules:	Must be either C, N or S. Must be N for Member share.						
TPL Paid Amount	18 Max	N (999999999999999.99)	S	None	NA	D060	S
Data Element Description:	Detail claim amount paid by third party insurer. (This is the TPL amount paid for this line item only. If multiple TPL details are being paid on one claim do not enter the total TPL paid amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50.						
Validation Rules:	Not allowed for posting dates after 12/31/2007 except on reversal records whose parent has a posting date before 1/1/2008.						
Type of Bill Code	3 Max.	AN	S			D091	S
Data Element Description:	A code indicating the specific type of bill. This three digit code requires 1 digit in each, in the following sequence: 1) Type of facility, 2) Bill Classification, 3) Frequency. UB92 requires 3 fields and the HIPPA 837 only requires 2.						
Validation Rules:	Must be on the master lookup table. Required on Institutional claims. Must be null for member share.						
Unit or Basis for Measurement Code	2 Max.	AN	S	None	Unit or Basis for Measurement Code (AN, L=2)	D053	S
Data Element Description:	Describes what format the Quantity field is in. MJ (minutes), HR (hours), Days (DA), Weeks (WK), Years (YR), Quarter (Q1), International Units (F2), UN (unit), and Miles (DH).						
Validation Rules:	Must be present for Encounter Transactions. Must be NULL for member share transactions.						

Information regarding Data Type

AN	Alpha numeric
ANPlus	Alpha numeric + special characters
ANDot	Alpha numeric + period
A	Alpha
N	Numeric
D	Data

Information regarding length

(000)	fixed length
(999)	variable length

Information regarding required field

Y	Yes, Data is required in this field for Original or Change New transactions
N	No, Data is not required in this field
S	Situational, Data is required in this field only when certain other criteria is met

Please note, the DD does not specify the severity of the edit. In most cases, it makes sense to set the severity to batch accept or batch reject. But, for business reasons, it may have been set to a Warning

Validation rule

This information is limited to business decisions. We do not go into parser validations, or data integrity validations

Error Category

A	Adjustment attribute
H	Header Attribute
M	Member (recipient) identification attribute
P	Provider identification attribute
R	Record attribute
S	Service Attribute

CHANGE LOG

Date	Changes	Changed By	Remarks/Reason
4/26/2005	(First draft)		
6/30/2007	Document is baselined at version 6. From now on, all changes will be implemented into the baseline document, and documented into the change log	Syed Aziz	One time document baselining.
6/30/2007	HIPAA related Tag (and DB) name changes.	Syed Aziz	Bugzilla 2255 and 2256.
7/25/2007	Changed existing baselined XML tag names to new baseline XML tag names.	Ramona Johnson	Update document baselining XML tag names.
8/10/2007	Reformat cells, update data element descriptions and field lengths. Under Validation Rules: List all Data Element lookup table names.	Ramona Johnson	Required HIPAA naming conventions.
8/16/2007	Added and removed text from several field descriptions and validations	Charles Rumberger	Sent back to EDS for review.
8/17/2007	Added and removed text from several field descriptions and validations.	Ramona Johnson	Analysis: Required and requested revisions.
8/18/2007	Reviewed updated text from several field descriptions and validations: Fixed length Type A (0) and A (00) changed to A. FC Posting Date Type N (999999999999999.99) changed to D (CCYY-MM-DD). Quotation marks were removed for readability and consistency. The word lookup added where the word table exists; the misspelled words and or punctuation corrections. Going forward, the revision history will be included in the Change Log.	Ramona Johnson	Analysis: Required and requested revisions.
8/23/2007	Revised the Data Source validation and description	Charles Rumberger	Additional information discovered about Data Source validation
8/24/2007	Data Elements: Updated the Data Source, Billing Provider First, Middle, and Last Name validation rules and/or descriptions. Made additional grammar/punctuation, and spelling corrections, and change log updated to reflect recent entries. The entry on 8/18/2007: The Fixed length Type A (0) and A (00) change to A should be disregarded. Question whether to show the DD field format as Type A and then drop the (0) and/or (00), but may be better to leave as is.	Ramona Johnson	Analysis: Required and requested revisions.
8/27/2007	Changed MCO to submitting organization in the header on the header tab.	Charles Rumberger	Sent for final review.
	Reviewed per the 'July 2007 Release Notes for Encounter' 'XML tag names 6/16/2007' section and found to comply	C. J. Kooyman	
	Changed release from 2.5 to 2.6 and changed CMO to FC on header tab submission type	Charles Rumberger	
8/29/2007	FC DD Elements: The header and detail page alphabetically sorted.	Ramona Johnson	Analysis: Client approved the required and requested FC DD for publication as of 08/29/07.

CHANGE LOG

10/20/2007	Removed the existing TPL Paid Amount data element field to include new additional data elements fields that will be used to store the cumulative sum of the three types of TPL records for a service record. i.e., total_medicare_paid_amount, medicare_tpl_type, other_payer_amount_paid_primary, other_payer_tpl_type_primary, other_payer_amount_paid_secondary, other_payer_tpl_type_secondary	Ramona Johnson	Analysis: Client required and requested 6 additional data elements be added: TPLs for medicare. Contains revised/added edit numbers and related edit details: Bug 2242
12/12/2007	FC, WPP & SSI data element revisions: A006A Original ID changed to a mandatory alphanumeric field with a maximum length of 80 characters must be provided. Edit D006E changed in functionality, description, message and severity. The new functionality checks for record types 'O and C' with an adjustment type of N. This edit will not apply to reversal records. And the value must be supplied not derived.	Ramona Johnson	FC, WPP & SSI Parser and Content Edit: Original ID D006A & E will be a required field beginning 2008 posting dates. Refer to Bug 2317.
1/17/2008	Reintroduced the TPL Paid Amount field with a validation change and required became situational. Changed id # on new COB fields from D03, D04, D05, D06, D07 and D08 to D103, D104, D105, D106, D107 and D108.	Charles Rumberger	Clarification for changes implementing on 1/1/2008
4/30/2008	Added documentation for POA_Indicator. Also added rows for additional Diagnosis Codes 10-18.	Phyllis Schmoller	Additional data needed for new fields.
10/8/2008	Modified Service Delivery Type to be an optional field.	Phyllis Schmoller	Changed per Charles request (Bug 2257).
10/14/2008	Added Claim Type for this LOB.	Phyllis Schmoller	Changed per Bug 2370.
11/14/2008	Modified ID# to be a 4-character field.	Phyllis Schmoller	Changed per Charles request.
11/17/2008	Changed validation rules to 'None' for National Health Plan ID, National Recipient ID and Rendering Provider First Name.	Phyllis Schmoller	Changes made per Bugzilla 2382.